IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 6595

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Katherine Lorenz
Deceased:	Taylor Zachary Oliver
Date of birth:	26 January 2000
Date of death:	1 December 2019
Cause of death:	1(a) Stab wounds to the neck and chest
Place of death:	21 Willow Grove, Wendouree, Victoria, 3355
Keywords:	Self-harm, mental health, access to services, post-discharge follow-up

INTRODUCTION

1. On 1 December 2019, Taylor Zachary Oliver (**Mr Oliver**) was 19 years of age when he died from self-inflicted injuries at his home in Wendouree, Victoria, where he lived with his mother, Kim Oliver (**Ms Oliver**) and stepfather, John Sampson (**Mr Sampson**).

2. Mr Oliver's first reported contact with mental health services was in 2014 when he was diagnosed and treated for cannabis use disorder by Ballarat Mental Health Services (**BMHS**). He was subsequently referred back to his general practitioner (**GP**) and encouraged to engage with drug and alcohol support services.

3. In May 2017, Mr Oliver was referred by his mother to BHS due to methamphetamine and cannabis use and psychotic symptoms. BMHS facilitated his inpatient admission to the Banksia ward at the Royal Children's Hospital for drug-induced psychosis. He was diagnosed with schizophrenia and commenced on paliperidone (antipsychotic) and sodium valproate (mood stabiliser). He was discharged on 17 July 2017 and returned to the care of his GP and a psychiatrist. While his mental health was stable and he was compliant with treatment, he remained pre-contemplative regarding his substance use.

4. On 8 October 2019, Mr Oliver presented to his GP reporting not sleeping, racing thoughts, and irritability. Though he did not present with signs of psychosis it was noted that he had self-ceased his medication in January 2019. His GP recommenced him on paliperidone and melatonin.

5. Between August and November 2019, Mr Oliver had multiple triages with concerns of a deterioration in his mental health. On 18 November 2019, Mr Oliver was admitted to the Ballarat Health Service Emergency Department (**ED**) following a marked decline of his mental state and taking an overdose of melatonin, paliperidone and sodium valproate. While he denied suicidal intent, he reported fleeting suicidal ideation. He also reported recent use of MDMA and cannabis.

6. Mr Oliver was assessed as experiencing a relapse of schizophrenia exacerbated by substance use. He was made subject to an assessment order under the *Mental Health Act 2014* (Vic) and admitted to the mental health ward. Mr Oliver was discharged about 36 hours later, his assessment order was revoked, and a plan was made to discharge him with a collaborative treatment plan involving mental health and Alcohol and Other Drug services.

7. On 21 November 2019, Mr Oliver attended a post-discharge review. He reported to be doing well, sleeping and eating well and denied suicidal ideation and psychotic symptoms. He reported compliance with his medication and wanting to remain abstinent from substances, accepting a referral for substance abuse treatment.

8. On 26 November 2019, Mr Oliver attended a scheduled psychiatrist review. He reported deteriorating mental health and identified that this was likely associated with recommencing daily cannabis use on 23 November 2019. He was observed to be apathetic and slow in his cognition and motor functions. He denied suicidal thinking and did not show signs of psychosis. A plan was agreed to introduce 5mg olanzapine as an adjunct to paliperidone with medications to be dispensed weekly. The psychiatrist noted a diagnostic impression of mental and behavioural disorder due to cannabis abuse (withdrawal), moderate risks of deliberate and accidental self-harm and a low risk of harm to others, and that his risk would likely escalate when using drugs and non-compliant with medications

9. On 29 November 2019, a clinician attempted to call Mr Oliver for a scheduled appointment, but he did not answer. They instead spoke to his mother who reported no changes since the psychiatrist review. She stated that he was using cannabis, had slowed speech, difficulties processing information, a blank face and was saying "yeah" repeatedly in the absence of anyone talking to him. She believed him to be compliant with medications. The clinician provided a handover to Mr Oliver's psychiatrist who advised that Mr Oliver should increase his olanzapine to 10mg.

10. Mr Oliver returned the clinicians call later that day. He reported feeling not too bad but not too good and had difficulty expanding on this. He reported that he couldn't think properly and took extended periods to respond to questions. He reported last smoking cannabis the previous day. The impact of cannabis on his mental state was reiterated, and he said that he would try not to continue using. He was unsure whether he had spoken to the Drug and Alcohol Clinician yet. He agreed to the recommendations to increase his olanzapine and attend another appointment in a few days.

11. At 3.20pm the same day, Mr Oliver presented to the ED complaining of a blocked ear following a burst eardrum three months earlier. He requested it to be cleaned out and a referral to an ENT. When called from the waiting room at 5.45pm he had left.

12. At 6.35pm, his mother contacted BMHS Access and Triage reporting that Mr Oliver seemed to be deteriorating, that he was less verbal and withdrawn, but was unable to provide more

specific information. No acute risks were noted. The Access and Triage clinician noted that recent contacts in the medical record indicated a similar presentation over recent days which was attributed to Mr Oliver's cannabis use.

13. There was no indication that Mr Oliver's presentation to the ED earlier that day was disclosed to the Access and Triage clinician and it's unclear whether his mother was aware of this. Mr Oliver declined to speak with the clinician on the telephone. An email was sent to his treating team advising of this contact.

14. At 8.13pm, Mr Oliver and his mother represented to the ED reporting that Mr Oliver was being seen by mental health in the community for drug induced psychosis, and was increasingly confused, disoriented and vacant. They left immediately after being taken into a bay.

15. On 30 November 2019, Mr Oliver's mental state continued to decline once again. He was reportedly drinking alcohol and crying a lot and had asked to go to the cemetery to see his deceased father.

THE CORONIAL INVESTIGATION

16. Mr Oliver's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

17. I took carriage of this investigation in February 2021 from Coroner English when I was appointed as a Coroner.

18. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

19. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

20. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Oliver's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

21. This finding draws on the totality of the coronial investigation into the death of Mr Oliver, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

22. On 1 December 2019, Mr Oliver was using cannabis and drinking alcohol. Later in the evening, Ms Oliver went out leaving Mr Oliver at home with Mr Sampson. While she was gone, Mr Oliver became more agitated, pacing up and down the hallway and enquiring as to Ms Oliver's whereabouts. Concerned, Mr Sampson called Ms Oliver asking her to return home as soon as she could.

23. Ms Oliver returned home between 9:30pm and 10:00pm. She found Mr Oliver "smoking a bong" in the kitchen which she confiscated before Mr Oliver went to his bedroom.

24. Moments later, Ms Oliver went to check on him after hearing "rustling" noises coming from his room. She found Mr Oliver with a pocketknife with which he stabbed himself in the neck. Ms Oliver called to Mr Sampson who attempted to restrain Mr Oliver while Ms Oliver called emergency services.

25. While waiting for emergency services, Mr Oliver stabbed himself again in the chest with a knife that he had retrieved from a knife block in the kitchen. He fell to the floor. They applied pressure to his wounds while waiting for help to arrive.

26. Victoria Police and Ambulance Victoria Paramedics arrived at about 11:15pm. On arrival, Mr Oliver was observed laying supine on the kitchen floor. His eyes were open and appeared conscious and breathing. At some point shortly after the arrival of police and paramedics, Mr

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Oliver lost consciousness and cardio-pulmonary resuscitation (CPR) was commenced. Despite efforts, Mr Oliver went into cardiac arrest and could not be revived. Mr Oliver was pronounced deceased at the scene at 11:38pm.

Identity of the deceased

27. On 1 December 2019, Taylor Zachary Oliver, born 26 January 2000, was visually identified by his mother, Kim Oliver, who signed a statement of identification.

28. Identity was not in dispute and required no further investigation.

Medical cause of death

29. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 December 2019 and provided a written report of her findings dated 8 May 2020.

30. The post-mortem examination revealed multiple sharp force injuries to the neck and chest in keeping with the reported circumstances.

31. Both neck injuries penetrated into the jugular veins. The left injuries penetrated into the pleural cavity and one chest injury penetrated into the pericardial cavity, through a major coronary artery and into the left ventricle of the heart. Dr Francis reported that the mechanism of death was primarily one of acute blood loss.

32. Toxicological analysis of post-mortem samples detected hydroxyrisperidone (Paliperidone)[2], olanzapine[3] and delta-9-tetrahydrocannabinol[4].

33. Dr Francis provided an opinion that the medical cause of death was *1 (a) stab wounds to the neck and chest*.

34. I accept Dr Francis' opinion.

[2] A Benzisoxazole derivative and active metabolite of risperidone clinically used as an antipsychotic.
[3] Atypical antipsychotic drug clinically indicated for mood stabilisation and as an anti-manic drug.
[4] The active form of cannabis (marijuana).

REVIEW OF CARE

35. Coroner English referred this matter to the Mental Health and Disability Team of the Coroners Prevention Unit (**CPU**)[5] for review of Mr Oliver's clinical care and management by BMHS. CPU reviewed the available material, including statements and medical records, and prepared a written advice dated 4 August 2021.

36. CPU focused primarily on three issues: (1) access to services, (2) discharge from hospital and (3) post-discharge follow-up.

Access to Services

37. Mr Oliver experienced a decline in his mental state in the three to four months leading up to his death. His illicit substance use was evidently a significant contributing factor to this deterioration.

38. Concerns were raised with this Court that appropriate support wasn't available and couldn't be accessed by Mr Oliver in the lead up to his death. Respectfully, these concerns are not supported by the evidence.

39. The evidence demonstrates that BMHS offered services on multiple occasions, however these were repeatedly declined until November 2019. CPU observed that four of Mr Oliver's five contacts with BMHS ended due to him and Ms Oliver declining further services. The records further revealed that Ms Oliver sought assistance from Mr Oliver's GP on multiple occasions and this resulted in various levels of mental health monitoring and support, medication review and changes and referral to BMHS.

Discharge from hospital

40. CPU opined that Mr Oliver's discharge from hospital in November 2019 was reasonable based on the medical records and statements provided to the Court.

41. The medical records suggested that at the time of discharge, Mr Oliver was no longer presenting with the symptoms he was experiencing on admission and there was no indication

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

that he was a risk to himself or others. CPU noted that substance induced psychosis lasts a relatively short time (from hours to days) until the effects of the drug wears off and therefore admission for same is typically short, whereas psychosis in the context of schizophrenia tends to persist for longer. The medical records indicate that Mr Oliver's condition had markedly improved by the time of his discharge.

42. Further, CPU reported that in the absence of current symptoms of mental illness and risk to self or others and Mr Oliver being agreeable to less restrictive treatment, he would not have satisfied the criteria for a temporary treatment order under the *Mental Health Act 2014* (Vic).

Post-discharge follow-up

43. CPU concluded that Mr Oliver's treatment post-discharge appeared reasonable.

44. CPU advised that the available information indicated that Mr Oliver's mental state remained stable for three days after discharge and his deterioration in mental state coincided with his return to cannabis use. A referral to drug and alcohol services was made at the first post-discharge review and BMHS staff engaged Mr Oliver in substance abuse treatment in the interim, including psychoeducation strategies, to prevent a return to drug use and discussion around residential treatment.

45. When Mr Oliver and his mother reported a deterioration in his mental state, Mr Oliver was promptly reviewed by a psychiatrist, his medications changed and his progress monitored. Although his mental state was deteriorating, CPU noted that there did not appear to be any indication of acute risks at that time to suggest that he was unsuitable for community treatment.

46. CPU noted that BMHS was not notified following Mr Oliver's presentation to the ED on 29 November 2019. CPU were of the view that it would have been reasonable for either the ED doctor or ED triage to alert BMHS given Mr Oliver presented with mental health concerns, left without being seen, was not known to present to ED regularly and there was no contraindication to making such a notification. As a consequence of not being informed, BMHS was unable to provide appropriate follow-up.

47. In their respective statements to this Court, Dr Anoop Lalitha, Director of Clinical Services at BMHS and Dr Pauline Chapman, Clinical Director of the ED, stated that it was not routine practice for the ED to notify BHMS when a current client presents to the ED with mental

health concerns and leaves before being seen. They indicated that notification could occur on a case-by-case basis depending on the presentation.

48. Dr Chapman stated that some BMHS clients are well known to ED due to frequent presentations in the context of their mental illness, and such patients often have clinical risk management plans formulated with all relevant stakeholders which outlines the expected response from ED. In such cases, the clinical risk management plan may indicate that mental health review is not indicated for every ED presentation. There was no evidence that Mr Oliver fit this cohort of patients, as there was no evidence of a clinical risk management plan in his medical record and his contact with the ED was minimal.

49. Dr Lalitha stated that other than the *Access and Triage Guideline*, there are no guidelines for clinicians around communication between ED and BMHS when a current client presents to ED with mental health concerns. The *Access and Triage Guideline* outlined the operations of the Access and Triage team. It did not discuss the expected communication between ED and BMHS when a current client presents to ED.

50. Dr Chapman stated that the *Behavioural Emergencies (including mental health): Management in the Emergency Department Clinical Practice Protocol* relates to current BMHS clients who present to ED with mental health concerns. This document directs ED staff to check for a clinical risk management plan, perform an assessment and contact BMHS if ED staff would like to refer or seek advice from BMHS. Based on this document, it appears that the expected communication between ED and BMHS when a current client presents to ED with mental health concerns is based on the ED staff member's discretion, unless otherwise directed in the client's clinical risk management plan.

51. In view of the above, it appears that there is little or no guidance for ED staff around communication with BMHS when a patient presents with mental health concerns, except for when the client has a current clinical risk management plan. In the absence of a clinical risk management plan, less may be known about the patient's risks and this would seem to suggest a need to notify BMHS for ongoing monitoring.

Ballarat Health Services Root Cause Analysis Investigation

52. In a statement to the Court, Dr Anoop Lalitha, Director of Clinical Services at BMHS, advised that an in-depth case review was conducted by BMHS using the Safer Care Victoria RCA protocol.

53. Dr Lalitha did not outline what, if any, issues with care or root causes were identified as a result of the RCA but reported that eight recommendations had been made which had all accepted and implemented. They included to:

a) Develop systemised processes to routinely monitor patients at risk of deteriorating in mental state including:

    i. Prompts for assessment
    ii. Actions to be taken – tiered response
    iii. Regular review and feedback process
    iv. Baseline functioning
    v. Agreed indicators for the purpose of monitoring deteriorating in a person's mental health.

b) Implement a standardised screening tool for every clinical assessment conducted in Access and Triage.

c) Implement a process where the Access and Triage clinical assessment is contemporaneously uploaded to the electronic medical record to support the provision of health across the organisation.

d) Develop a process where all clients have a comprehensive care plan that informs care. The process will ensure all staff are aware of the individual care plan and who is responsible for updating. The care plan will include:

    i. Care interventions
    ii. Individualised parameters for escalation of care
    iii. Monitoring requirements
    iv. Reassessment needs
    v. Indicators for the agreed purpose of monitoring deteriorating in a person's mental health
    vi. Client support systems
    vii. Incorporation of the family's knowledge around early warning signs
    viii. Agreed plans – client, family and care givers – external and internal to the health service.

e) Implement a process where care of clients at risk of acute deterioration that may require escalation of care are handed over to the appropriate staff for continuation of care after hours.

f) Implement a shift-to-shift type ISBAR tool that supports the communication of critical information at transitions of care in a timely manner.

g) Consider an acute crisis response team model of care whose primary function is to provide responsive after hours care to the deteriorating client.

h) Implement a formal process when families/carers have concerns that further information is gathered to understand the exact nature of concerns. This information should inform the risk assessment and comprehensive care plan. This process should involve tools to gather information from families/carers and access to a support network such as carer consultants.

54. CPU considered that these changes were comprehensive and in line with recommendations of the Royal Commission into Victoria's Mental Health System. CPU opined that they are likely to improve overall patient care and the experience of families involved with the service. I accept and adopt CPU's advice in this regard.

55. These recommendations, however, do not address communication between BMHS and the ED. Accordingly, I have formed the view that it is appropriate for me to make a recommendation in this regard.

RECOMMENDATION

56. Pursuant to section 72(2) of the Act, I make the following recommendation:

a) To improve patient safety and responsiveness of BMHS to clients in crisis, Ballarat Health Services embed in relevant policies/procedures/protocols/guidelines a requirement for ED staff to notify BMHS when a current client of BMHS presents to ED with mental health concerns, including when they leave without being seen, unless the patient has a current clinical risk management plan indicating that routine notification of such presentations is contraindicated.

57. In making this recommendation, I take note that Ballarat Health Services have already taken steps to improve the response to acute mental health presentations in the ED.

58. Dr Rosemarie Eyre, Registrar in Medical Leadership, Management and Administration, provided a statement to the Court dated 11 August 2022 and reported that the following measures have been, or are being, implemented:

a) Emergency Mental Health clinician services (EDMS) was created and the EDMH clinician is collated in the Emergency Department to facilitate referrals, face to face assessment and secondary consultations.

b) Acute Response Team (ART) was commenced to respond to the acute crisis presentations in the community and provide in reach care in the consumer's home environment. The role of the ART team is to provide assertive community treatment to consumers in the community.

c) A referral pathway was developed to refer consumers with mental health issues from the Emergency Department to mental health triage services, expecting all referrals to be coming from the medical doctors. It is currently being reviewed to facilitate timely referrals without delay with the support of the Emergency Department nurses.

d) A new clinical practice guideline for mental health assessments in the Emergency Department is being developed in consultation with the Emergency Department clinical lead, in which the pathways and decision making points will be clearly specified.

FINDINGS AND CONCLUSION

59. Pursuant to section 67(1) of the Act, I make the following findings:

a) the identity of the deceased was Taylor Zachary Oliver, born 26 January 2000;

b) the death occurred on 1 December 2019 at 21 Willow Grove, Wendouree, Victoria, 3355, from stab wounds to the neck and chest;

c) the death occurred in the circumstances described above; and,

d) having considered all of the circumstances, particularly the lethality of the means chosen, I am satisfied that Mr Oliver intentionally ended his own life in the setting of significant mental illness.

60. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

61. I direct that a copy of this finding be provided to the following:

    Kim Oliver, Senior Next of Kin

    Ballarat Health Services

    Annabelle Mann, General Counsel, Royal Children's Hospital

    Senior Constable Carey Heap, Coroner's Investigator

Signature:

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Coroner Katherine Lorenz

Date : 15 December 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.